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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165234	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor	516 Thirteenth Street Wellman, IA 52356

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on observation, clinical record review and staff interview, the facility failed to ensure residents are treated with dignity while being provided care for 2 of 4 residents reviewed. (Residents #14, #21) The facility reported census was 46. Findings include: 1. According to the Quarterly Minimum Data set (MDS) with an assessment reference date of 4/3/24, Resident #14 had a severely impaired cognitive status. Resident #14 required total dependence with mobility, transfers, dressing, toilet use and personal hygiene needs. The MDS documented Resident#14's diagnoses included Cerebral palsy, obstructive uropathy. During an observation on 5/2/24 at 1:50 p.m. Resident #14 was propelled back to his room and transferred into bed with a mechanical lift and assistance of two staff members (Staff D, Certified Nurses Aide (CNA)/Staff P, CNA). Both staff donned proper personal protective equipment (PPE) in accordance with Enhanced Barrier Precaution (EBP) protocols. Staff P proceeded to provide peri care and noted the resident was a little red, but was unaware where a barrier cream was. While providing care, Staff P placed the catheter bag on the bed, head level and when rolling Resident #14 to his left side, Resident #14's face was positioned directly on the catheter bag. Staff P failed to cleanse the supra pubic catheter tubing and when emptying the catheter bag, failed to use an alcohol swab to cleanse the stop valve tubing. Staff P placed the catheter bag on the bed frame and placed a blanket over the resident before leaving. 2. According to the Quarterly MDS with an assessment reference date of 4/5/24, Resident #21 had a minimally impaired cognitive status. Resident #21 required limited assistance with mobility and transfers. Moderate to maximal assistance with dressing, toilet use and personal hygiene needs. Resident #21 was frequently incontinent of bladder and always incontinent of bowel. During an observation on 5/7/24 at 8:00 a.m. a strong odor of urine detected on 100 hall, permeating primarily from room [ROOM NUMBER] (Resident #21's room). During an observation on 5/9/24 at 12:15 p.m. Resident #21 sat in his wheelchair with TV on, but appeared asleep. A strong urine odor was noted upon entering Resident #21's room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Parkview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 516 Thirteenth Street Wellman, IA 52356	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/13/24 at 12:00 p.m. Resident #21's room was currently empty with a housekeeping cart sitting outside the doorway. One full urinal and one partially full urinal was sitting on the floor. A urine stain was noted beneath the Resident #21' s bed. When the sheets were pulled back, two urine stains were noted on the sheet. In an interview on 5/13/24 at 12:00 p.m. Staff X, Housekeeping Supervisor, stated room [ROOM NUMBER] is the worst room for odors due to the residents spilling their urinals onto their sheets or the floor. Staff X stated when she entered the room today, there were wet briefs and pull ups left in the room adding to the odor problem.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on observations, clinical record review and staff interviews, the facility failed to ensure the facility remains free of persistent odors. (Resident #21) The facility reported census was 46. Findings include: According to the Quarterly Minimum Data Set (MDS) with an assessment reference date of 4/5/24, Resident #21 had a minimally impaired cognitive status. Resident #21 required limited assistance with mobility and transfers. Moderate to maximal assistance with dressing, toilet use and personal hygiene needs. Resident #21 was frequently incontinent of bladder and always incontinent of bowel. During an observation on 5/7/24 at 8:00 a.m. a strong odor of urine detected on 100 hall, permeating primarily from room [ROOM NUMBER] (Resident #21's room). During an observation on 5/9/24 at 12:15 p.m. Resident #21 sat in his wheelchair with the television on, but appeared asleep. A strong urine odor was noted upon entering Resident #21's room. During an observation on 5/13/24 at 12:00 p.m. Resident #21's room was currently empty with a housekeeping cart sitting outside the doorway. One full urinal and one partially full urinal was sitting on the floor. A urine stain was noted beneath the Resident #21' s bed. When the sheets were pulled back, two urine stains were noted on the sheet. In an interview on 5/13/24 at 12:00 p.m. Staff X, Housekeeping Supervisor, stated room [ROOM NUMBER] is the worst room for odors due to the residents spilling their urinals onto their sheets or the floor. Staff X stated when she entered the room today, there were wet briefs and pull ups left in the room adding to the odor problem.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 22506 Based on clinical record review, the facility failed to complete treatment of wounds in accordance with physician orders for 2 of 2 resident reviewed. (Resident #12, #15) The facility reported census was 46. Findings include: 1. According to a Minimum Data Set (MDS) with a reference date of 4/8/24, Resident #15 had a Brief Mental Status (BIMS) score of 8 which indicated a moderately impaired cognitive status. Resident #15 was independent with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #15's diagnosis included Non-Alzheimer's dementia, septicemia, chronic obstructive pulmonary disease and respiratory failure. According to Resident #15's Physician's orders dated 4/24/24 and April and May 2023 Treatment Administration Record (TAR), Resident #15 was to have her face washed four times per day with bacitracin and Vaseline on gauze applied over her nose and ears. The April TAR indicated this treatment was not completed two times on 4/25/24, and the May TAR indicated this treatment was not completed three times on 5/1/24. According to Resident #15's Physician's orders dated 4/22/24 and April and May 2023 Treatment Administration Record (TAR), Resident #15 was to have Bacitracin Ointment applied to her face twice daily. The order was not transcribed on the April TAR and consequently no treatments were completed as ordered on 4/23, 2/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30. The May TAR indicated this treatment was not completed on 5/1/24. According to Resident #15's Physician's order dated 4/24/24 and April and May 2023 Treatment Administration Record (TAR), Resident #15 was to have Sulfamylon applied to her scalp, right wrist and left finger four times per day. The April and May TAR indicated this treatment was not completed twice on 4/25/24, not at all on 4/29/24 and 4/30/24 and only completed once on 5/1/24. According to Resident #15's Physician's order dated 4/24/24 and April and May 2023 Treatment Administration Record (TAR), Resident #15 was to have Sodium Chloride Nasal Solution 1 spray in both nostrils four times per day and a cotton applicator to clean and remove dead skin from her nostrils four times a day. The order was not transcribed on the April TAR and consequently no treatments were completed as ordered on 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30. The May TAR indicated this treatment was not completed three times on 5/1/24. 2. According to the minimum data set (MDS) with an assessment reference date of 4/6/24, Resident #12 had a Brief Interview for Mental Status (BIMS) of 14 indicating an intact cognitive status. Resident #12 required dependent to maximal assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #12 was coded as always incontinent of bowel and bladder. Diagnosis included coronary artery disease, peripheral vascular disease, renal insufficiency, diabetes mellitus, cerebrovascular accident (stroke), hemiplegia and chronic obstructive pulmonary disease. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Resident #12's Treatment Administration Record (TAR) for April 2024, Resident #12 was to have Triple Antibiotic External Ointment applied to his right inner thigh abrasion twice daily until healed. The TAR indicated treatments were not provided on the evenings of 4/3, 4/21 and 4/27. According to Resident #12's TAR for April 2024, Resident #12 was to have Urea Cream 10% applied to his bilateral lower legs twice daily. The TAR indicated treatments were not provided on the evenings of 4/3 and 4/21.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 22506 Based on observation, clinical record review, bathing records and staff interview, the facility failed to ensure residents are provided adequate personal hygiene services to include at least two bathing opportunities per week for 3 of 4 residents reviewed and failed to provide catheter care in accordance with professional standards of practice. (Residents #12, #14, #18) The facility reported census was 46. Findings include: 1. According to Quarterly Minimum Data Set (MDS) with an assessment reference date of 4/6/24, Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated an intact cognitive status. The MDS documented that the resident required dependent to maximal assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. The MDS coded Resident #12 as always incontinent of bowel and bladder. The MDS documented the resident with diagnoses which included coronary artery disease, peripheral vascular disease, renal insufficiency, diabetes mellitus, cerebrovascular accident (stroke), hemiplegia and chronic obstructive pulmonary disease. The Care Plan for the resident documented a focus area with initiated date of 11/03/2015 as follows: the resident needs help with Activities of Daily Living (ADL)'s due to a stroke and weakness to the left side, chronic pulmonary disease with shortness of breath, impaired vision and incontinence due to inability to feel the urge to void of have bowel movements. The Care Plan directed the staff with the following interventions; encourage bathing twice a week as tolerates, inspect skin during showers and alert charge nurse to any skin issues, check nail length and trim/clean on bath days and as necessary, and report any changes to charge nurse. When the resident declines showers/baths staff are to re-approach at a later time and offer shower again. The revision date for the previous intervention was 3/24/24. According to the Shower Schedule undated document given to the survey team, Resident #12 was to receive shower opportunities on Tuesdays and Fridays. Bathing records during April and May 2024 indicated Resident #12 was provided bathing opportunities as scheduled on all dates except 4/2 and 4/26. Bathing records indicated he refused showers on 4/16 and 4/30. 2. According to the Quarterly MDS with an assessment reference date of 4/3/24, Resident #14 had a severely impaired cognitive status. The MDS documented Resident #14 required total dependence with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #14 had a suprapubic catheter and was always incontinent of bowel. The MDS documented the resident had diagnoses which included cerebral palsy, obstructive uropathy. The Care Plan for Resident#12 documented a focus area with initiated date of 11/2/2017 as follows; Activated of Daily Living (ADL's) self care performance deficit related to musculoskeletal impairment, limited mobility, cerebral palsy, intellectual disabilities, scoliosis, seizures and congenital hearing loss. The Care Plan directed staff with the intervention to offer bathing/showering twice weekly and as necessary, check nail length then trim and clean on bath day and as necessary. Report any changes to the nurse, with revision date of 4/16/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to shower schedules, Resident #14 was to receive shower opportunities on Tuesdays and Fridays. Bathing records during April and May 2024 indicated Resident #14 was not provided bathing opportunities as scheduled on 4/2, 4/5, 4/9, 4/16, 4/19 and 5/3. During an observation on 5/2/24 at 1:50 p.m. Resident #14 was propelled back to his room and transferred into bed with a mechanical lift and assistance of two Certified Nurses Aides (CNA) staff members (Staff D/Staff P). During the observation Staff P failed to cleanse the supra pubic catheter tubing and when emptying the catheter bag, failed to use an alcohol swab to cleanse the stop valve tubing. Staff P CNA placed the catheter bag on the bed towards the head of the bed, and when the staff rolled the resident over to the left side the resident's face was in contact with the catheter bag. Observation on 5/7/24 at 8:15 a.m. Resident provide morning care by Staff D, CNA . Resident's face and axilla washed, peri care provided, resident dressed and oral hygiene completed. Proper Personal Protective Equipment (PPE) and hand hygiene used. Staff D did not cleanse Resident's supra pubic catheter tubing or site. Blood noted in catheter tubing. Braces applied to feet Resident was transferred properly via the mechanical lift with assistance Staff D, CNA and Staff V, CNA. The Resident was then propelled to the dining room for breakfast. In an interview on 5/7/24 at 2:10 p.m. the Director of Nursing (DON) reported catheter care is to be completed each shift and as needed if the tubing becomes soiled. Catheter care includes cleansing the tubing from the resident up to 6 inches or so from the body. Nurse aides are responsible for the basic cleansing needs, unless there is a supra pubic catheter that has a split gauze, in which a nurse would be responsible to cleanse and change the dressing each shift. The DON stated the process when emptying the catheter bag each shift includes ensuring an alcohol wipe is used to cleanse the stop valve before returning it back into its closed position. 3. According to the MDS with an assessment reference date of 1/24/24, Resident #18 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated an intact cognitive status. The MDS documented that Resident #18 required moderate to maximal assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. The MDS documented that the resident had diagnoses which included congestive heart failure, gastroesophageal reflux disease. The Care Plan for Resident#18 identified a focus area with initiated date of 1/30/2024 as ADL self-care performance deficit. The Care Plan directed staff with interventions as follows; offer bathing/showering twice weekly and as necessary, check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Revision date of the interventions documented as 2/7/2024. According to shower schedules, Resident #18 was to receive shower opportunities on Mondays and Thursdays. Bathing records during April and May 2024 indicated Resident #18 was not provided bathing opportunities as scheduled on 4/1, 4/8, 4/11, 4/22 and 5/2. Bathing records indicated he refused showers on 4/18, 4/29 and 5/6. According to facility catheter care policy: The facility will maintain consistent and adequate hygiene standards for residents with an Indwelling Catheter to maintain function and prevention of infection or complications. RESPONSIBILITY: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Staff, Licensed Nurses, Nursing Administration, & Director of Nursing. PROCEDURE: Gather Supplies: Towel, Incontinent Wipes, Incontinent Pad. Identify Resident & Explain Procedure. Provide Privacy Perform Hand Hygiene & Apply Gloves If able, Position Female Resident in the Dorsal Recumbent Position; Males in the Supine Position. Place Incontinent Pad under Resident's Hips. Place sheet over Resident; Only exposing Perineal Area. Perform Incontinence Care per facility protocol prior to providing Catheter Care. Female: With non-dominant hand, retract labia to fully expose urethral meatus and Catheter insertion site. Maintain hand position throughout the procedure. Cleanse the labia major using soap and water and a clean washcloth, cleanse downward motion. Change the position of the washcloth with each downward stroke. Repeat for the labia minor using a clean washcloth cleansing down the length of the Catheter at least 4. Do not allow the washcloth to drag on resident's skin or bed linen. Male: Retract the foreskin of the uncircumcised penis to expose urethral meatus and Catheter insertion site. Maintain hand position throughout the procedure. Cleanse the urethral meatus using soap and water and a clean washcloth down the length of the catheter at least 4. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cleanse glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Avoid pulling the Catheter during Cleansing. Remove Gloves, Perform Hand Hygiene. Apply Gloves & Reposition Resident's Clothing/Bedding to ensure Privacy/Comfortable. Discard Contaminated Items in Designated Containers. Remove Gloves & Perform Hand Hygiene.